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104TH CONGRESS
1ST SESSION

# H. R. 2350

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans.

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IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 18, 1995

Mr. COBURN introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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# A BILL

To amend title XVIII of the Social Security Act to provide protections for medicare beneficiaries who enroll in medicare managed care plans.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the ''Medicare Patient Choice and Access Act of 1995''.

**SEC. 2. FINDINGS.**

Congress finds the following:

(1) There should be no unreasonable barriers or impediments to the ability of individuals enrolled in health care plans to obtain appropriate specialized medical services.

(2) The patient's first point of contact in a health care plan must be encouraged to make all appropriate medical referrals and should not be constrained financially from making such referrals.

(3) Some health care plans may impede timely access to specialty care.

(4) At any time, patients must be able to access out-of-network items, treatment, and services at an additional cost to the patient which is not so prohibitive that they are deterred from seeing the health care provider of their own choice.

(5) Specialty care must be available for the full duration of the patient's medical needs and not limited by time or number of visits.

(6) Direct access to specialty care is essential for patients in emergency and non-emergency situations and for patients with chronic and temporary conditions.

**SEC. 3. PROTECTION FOR MEDICARE HMO ENROLLEES.**

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended—

(1) in subsection (c)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (k)'', and

(2) by adding at the end the following new subsection:

''(k) BENEFICIARY PROTECTION.—

''(1) MINIMUM LOSS RATIO.—

''(A) IN GENERAL.—Each eligible organization shall have a loss-ratio that is not less than 85 percent for each contract year.

''(B) LOSS RATIO DEFINED.—In subparagraph (A), the term 'loss-ratio' means, with respect to an organization for a contract year, the ratio of (i) the anticipated aggregate benefits provided under this section to enrollees for the year, to (ii) the aggregate amount of the premiums collected (including payments to the organization under subsection (a) for the year, as estimated on the basis of incurred claims experience and earned premium for the year.

''(2) ASSURING ADEQUATE IN-NETWORK ACCESS.—

''(A) TIMELY ACCESS.—An eligible organization that restricts the providers from whom benefits may be obtained must guarantee to enrollees under this section timely access to pri-

mary and specialty health care providers who are appropriate to the enrollee's condition.

''(B) ACCESS TO SPECIALIZED CARE.—Enrollees must have access to specialized treatment when the treating provider deems necessary. This access may be satisfied through contractual arrangements with specialized providers outside of the network.

''(C) CONTINUITY OF CARE.—An eligible organization's use of case management may not create an undue burden for enrollees under this section. An organization must ensure direct access to specialists for ongoing care as so determined by the case manager in consultation with the specialty care provider. This continuity of care may be satisfied for enrollees with chronic conditions through the use of a specialist serving as case manager.

''(3) ASSURING OUT-OF-NETWORK ACCESS.—

''(A) IN GENERAL.—An eligible organization that contracts with a specific network of providers must not limit the ability of its enrollees under this section to seek at any time items, treatment, and services from out-of-network providers for all covered benefits.

''(B) REIMBURSEMENT FOR OUT-OF-NETWORK SERVICES.—An eligible organization under this section shall provide for reimbursement for the enrollee, consistent with the cost-sharing schedule established under subparagraph (C), with respect to out-of-network services which are described in subparagraph (A), so long as the services were medically appropriate, and were covered benefits in-network.

''(C) ESTABLISHMENT OF COST-SHARING SCHEDULE.—Each eligible organization shall establish (by not later than one year after the enactment of the Medicare Patient Choice and Access Act of 1995) a cost-sharing schedule which applies to payment required under subparagraph (B) for out-of-network services.

''(4) GRIEVANCE AND APPEALS PROCESSES.—

''(A) GRIEVANCE PROCESS.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this section.

''(B) BOARD OF APPEALS.—

''(i) IN GENERAL.—Each eligible organization shall establish a board of appeals to hear and make determinations on complaints by enrollees concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.

''(ii) COMPOSITION.—A board of appeals of an eligible organization shall consist of—

''(I) representatives of the organization, including physicians, nonphysicians, administrators, and enrollees;

''(II) consumers who are not enrollees; and

''(III) providers with expertise in the field of medicine which necessitates treatment.

''(iii) DEADLINE FOR DECISION.—A board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

''(C) APPEAL TO SECRETARY.—Nothing in this paragraph may be construed to replace or supercede any appeals mechanism otherwise provided for an individual entitled to benefits under this title.

''(5) NOTICE OF ENROLLEE RIGHTS AND ENROLLEE INFORMATION CHECKLIST.—

''(A) IN GENERAL.—Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee's rights under this section and a copy of the most recent enrollee information checklist for the organization (as described in subparagraph (C)).

''(B) RIGHTS DESCRIBED.—The explanation of rights under subparagraph (A) shall include an explanation of—

''(i) the enrollee's rights to benefits from the organization;

''(ii) the restrictions on payments under this title for services furnished other than by or through the organization;

''(iii) out-of-area coverage provided by the organization;

''(iv) the organization's coverage of emergency services and urgently needed care;

''(v) the organization's coverage of out-of-network services, including services that are additional to the items and services covered under parts A and B; and

''(vi) appeal rights of enrollees.

''(C) ENROLLEE INFORMATION CHECKLIST.—For purposes of subparagraph (A), the term 'enrollee information checklist' means, with respect to an eligible organization for a year, a list containing the following information (provided in a manner that permits consumers to compare organizations with respect to the information):

''(i) For each plan, on—

''(I) the premium for the plan,

''(II) identity, location, qualifications and availability of providers in any provider networks of the plan,

''(III) the number of individuals enrolling and disenrolling from the plan,

''(IV) procedures used by the plan to control utilization of services and expenditures,

''(V) procedures used by the plan to assure quality of care,

''(VI) the plan's loss ratio, and

''(VII) rights and responsibilities of enrollees.

''(ii) In addition, for each managed care plan, on—

''(I) restrictions on payment for services provided outside the plan's provider network,

''(II) the process by which services may be obtained through the plan's provider network,

''(III) coverage for out-of-area services, and

''(IV) any exclusions in the types of providers participating in the plan's provider network.

''(6) RESTRICTIONS ON PROVIDER INCENTIVE PLANS.—

''(A) IN GENERAL.—Each contract with an eligible organization under this section shall

provide that the organization may not operate any provider incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a provider or provider group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a provider or provider group at substantial financial risk (as determined by the Secretary) for services not provided by the provider or provider group, the organization—

''(I) provides stop-loss protection for the provider or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number (and type) of providers placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organiza-

tion who receive services from the provider or the group, and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PROVIDER INCENTIVE PLAN DEFINED.—In this paragraph, the term 'provider incentive plan' means any compensation arrangement between an eligible organization and a provider or provider group that may directly or indirectly have the effect of reducing or limiting medically necessary services provided with respect to individuals enrolled with the organization.

''(7) ADDITIONAL DEFINITIONS.—

''(A) IN-NETWORK.—The term 'in-network' means services provided by health care providers who have entered into a contract or agreement with the organization under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the organization under this section.

''(B) NETWORK.—The term 'network' means, with respect to an eligible organization, the health care providers who have entered into a contract or agreement with the organization under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the organization under this section.

''(C) OUT-OF-NETWORK.—The term 'out-of-network' means services provided by health care providers who have not entered into a contract agreement with the organization under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the organization under this section.''.

(b) CONFORMING AMENDMENTS.—Section 1876 of such Act is further amended—

(1) by striking subparagraph (E) of subsection (c)(3);

(2) by striking paragraphs (4) and (5) of subsection (c); and

(3) by striking paragraph (8) of subsection (i).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into or renewed under section 1876 of the Social Security Act after the expiration of the 1-year period which begins on the date of the enactment of this Act.

**SEC. 4. APPLICATION OF PROTECTIONS TO MEDICARE SELECT POLICIES.**

(a) IN GENERAL.—Section 1882(t)(1) of the Social Security Act (42 U.S.C. 1395ss(t)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (E);

(2) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(3) by adding at the end the following new subparagraph:

''(G) notwithstanding any other provision of this section to the contrary, if the issuer of the policy—

''(i) meets the requirements of section 1876(k) with respect to individuals enrolled under the policy in the same manner such requirements apply with respect to an eligible organization under such section with respect to individuals enrolled with the organization under such section, and

''(ii) discloses (in a form and manner specified by the Secretary) the loss ratio described in subsection (r)(1) most recently calculated for purposes of such subsection.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to policies issued or renewed on or after the expiration of the 1-year period which begins on the date of the enactment of this Act.

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